Section 3.18 Children's Long-Term Support (CLTS) Waivers – 2011 – Revised 2/13/12

Funding: Medical Assistance, CFDA number 93.778. The federal government has identified Medical Assistance as a program of higher risk. Auditors will need to ensure that they meet the federal requirements for testing a major program within the context of also ensuring they meet the requirements from the Department of Health Services.

The CLTS Waivers are home and community-based programs established under Section 1915(c) of the Social Security Act and are part of the Wisconsin Medicaid Program. The CLTS Waivers are three separate waivers that serve children who have a developmental disability (DD), a severe emotional disturbance (SED), or a physical disability (PD).

The objective of these waivers is to provide program participants and their families with choices about where and how the child lives in the community by providing that child with individualized services and supports. Services permit children to reside with their families instead of some type of institution or alternate care setting.

The Division of Long Term Care (DLTC) contracts with county agencies to build provider networks for the coordination and delivery of CLTS Waiver funded services. County agencies have an addendum to the County Contract for all three CLTS Waivers. Contracts with two private agencies have also been established to ensure the coordination and delivery of autism services under the DD and SED waivers. The private agency also has a standard contract with similar terms to the county contract. The State/County contract addendum or contract prescribes the requirements necessary for proper implementation and operation of this program by agencies and references other documents which also prescribe proper operation of these programs. DLTC refers to both the county and private agencies as county waiver agencies (CWAs) and issues standard program policy and procedure information to all CWAs. The key document referenced in the contract is the *Medicaid Home and Community-Based Services Waivers Manual*. (See link/site information: http://dhs.wisconsin.gov/bdds/waivermanual/index.htm).

During 2011, the Department of Health Services implemented a Third Party Administration (TPA) system for payment of CLTS waiver service claims. This change enables the Department to meet federal requirements for a standardized, state-wide Medicaid Management Information System for adjudicating and processing claims and encounter data collection. County waiver agencies transitioned to TPA claims processing on a regional basis throughout 2011, according to the following schedule:

CLTS Waivers TPA Schedule	
April 1, 2011	Lutheran Social Services St. Francis Children's Center
August 1, 2011	Southeastern Region
September 1, 2011	Southern Region
October 1, 2011	Northeastern Region
November 1, 2011	Western Region
December 1, 2011	Northern Region

After transitioning to TPA claims processing, county waiver agencies no longer report waiver expenditures to the DHS Human Services Reporting System (HSRS) for expenses incurred on or after the TPA transition date. For this reason, waiver expenditures in CY 2011 are reported in HSRS for expenditures incurred prior to the TPA transition date, and are included in the encounter data in the CLTS data warehouse for expenditures incurred on or after the TPA transition date.

Risk assessment

The Department of Health Services has designated the CLTS program to be a state major program when the auditee receives funding for any/all of the CLTS Waivers directly from the Department.

Compliance requirements and suggested audit procedures

All of the following compliance requirements in this section apply to individual waiver participants and should be tested through review of the participant's agency files.

Findings of noncompliance – Even limited or seemingly inconsequential noncompliance with certain program requirements can reflect or result in a profound impact on the quality of services and quality of life of program participants. Therefore, all findings of noncompliance need to be reported in the Schedule of Findings and Questioned Costs. If it is unclear whether a particular situation constitutes noncompliance, call or send an email to the contact person listed at the end of this section for guidance.

For each finding of noncompliance, the auditor does not usually need to determine questioned costs but does need to provide the identifying number (MCI Number) for each participant involved in the finding (not the participant's name), the compliance requirement (what should be), and the condition found (what is). Recommendations for corrective action are especially valuable if the findings indicate a systemic problem with the county's administration of these waivers.

The Department will typically calculate potential disallowances based on the nature of the noncompliance. For example, the potential disallowance for a county's failure to re-certify a participant would be the amount of waiver funds spent on the participant's behalf during the time since the end of the period covered by the previous certification or re-certification. Whether the Department will require full or partial repayment for that amount will depend on the nature and circumstances of the noncompliance and the county's previous record of compliance.

When presenting findings, identify the program and the specific compliance requirement, for example "CLTS A. Qualified Providers"

CLTS A. Qualified Providers

Compliance requirement(s)

Providers must meet the standards that apply to the Medicaid Waiver allowable services for which they claim reimbursement. These standards are contained in the *Medicaid Home and*

Community-Based Services Waivers Manual in Chapter IV. The sections for each service are headed by two subtitles: "Service Requirements/ Limitations/ Exclusions" and "Standards." Both sections contain compliance requirements for providers which must be met. County waiver agencies have contractually agreed, and must be able to assure the department that all providers comply with these requirements. This expectation does not apply in the same way to facilities licensed by the State (CBRFs, and 3-4 Bed Adult Family Homes). The possession of a current license is considered evidence of compliance for most of the expectations. The county waiver agency, though, must make sure the provider agency is properly licensed.

Suggested audit procedure(s)
Determine if the CWA has assessed provider compliance with the provisions listed under "Service Requirements/ Limitations/ Exclusions" and "Standards" for the following services:

- Counseling and Therapeutic Services (SPC 507.03)
- Daily Living Skills Training (SPC 110)
- Intensive In-Home Treatment Services (SPC 512)
- Respite Care (SPC 103)
- Supportive Home Care (SPC 104)

For each of these services, the *Medicaid Home and Community-Based Services Waivers Manual* will include a list of minimum qualifications and/or training requirements. This list will also indicate that the provider must meet specific unique training needs identified by the family and the CWA, as required in order to provide appropriate services to the individual child.

For each of the five services, the CWA is required to maintain within the child's record documentation that specifies the minimum qualifications and/or training requirements, including the unique training needs identified by the family and the county waiver agency as required in order to provide appropriate services to the individual child, as well as documentation that demonstrates that the provider met the minimum training requirements prior to being determined to be qualified to provide the service identified.

CLTS B. Service Plan Development
Compliance requirement(s)
The Individual Service Plan represents an agreement between the CWA and the participant as to how the assessed needs of the child will be met, and how the services will help the participant reach his/her individual outcomes. The ISP must be reviewed every six months in a face-to-face meeting with the participant and his/her guardian, if applicable. During the 6-month review, participants must be informed that they may:

1. Request a change in type, amount or frequency of service;
2. Request new or additional service(s) not currently provided, or
3. Choose to change providers of current services by selecting another provider from the Medicaid Waivers Provider Registry or by asking that the waiver agency assist in qualifying a provider not currently listed on the Registry.

Suggested audit procedure(s)
For the waiver services listed above, determine whether the CWA met the CLTS program requirements for the participant's Individual Service Plan (ISP) development.

CLTS C. Prior Authorization

Compliance requirement(s)

The CWA must preauthorize all CLTS provider services, and submit an accurate authorization to both the provider and the TPA, to validate the provider's payment for a given service. CMS requires use of a national code set when paying and reporting the waiver claims, thus CWAs must use the national Health Insurance Portability and Accountability Act of 1996 (HIPAA) codes. Stan[illegible] TPA. The[illegible]ge.

Section CLTS C deleted 2/13/12

Suggested audit procedure(s)

For the five services listed above, determine whether the CWA appropriately issued the service authorization notification to the provider and to the TPA claims vendor. The TPA claims vendor issues encounter-level claims data to the Department's CLTS data warehouse on a monthly basis. Analyze the claims data to ensure the TPA claims vendor correctly adjudicated, processed and paid the claim, according to the CWA's authorization notice.

CLTS D. Cost Sharing

Compliance requirement(s)

The audit is intended to determine if cost-share requirements have been met. Cost sharing only affects CLTS Waiver participants who are eligible under Medicaid Groups B or C. When a cost share applies, the child's eligibility for waiver services can only be maintained if the proper amount of their cost-share liability is paid in a timely manner.

The county waiver agency is required to establish Cost Sharing Agreements with the participant's family where appropriate. The county must maintain a record system that is able to track and document that the family has paid the appropriate cost share amount and that the cost share has been correctly applied toward waiver-covered services. If the participant pays the provider directly, the waiver agency must have a method to ensure the correct amount of the cost-share obligation has been correctly paid. The cost-share requirement does not apply for those months in which the waiver participant does not receive any waiver-funded services. The amount of the cost share cannot be higher than the cost of services for any month. For additional information, see Section 3.04 of the *Medicaid Home and Community-Based Services Waivers Manual* (http://dhs.wisconsin.gov/bdds/waivermanual/index.htm).

With the transition to TPA, county waiver agencies are required to notify DHS directly of any CLTS Waiver participant who has been assessed a cost share.

Suggested audit procedure(s)

For each participant file in the sample, the auditor should obtain the current copy of the MA Waiver Eligibility and Cost Sharing Worksheet (Form F-20919) and/or CARES screen for review. Line 11 on the F-20919 form will indicate whether the participant has a cost sharing obligation. For those waiver participants where cost sharing is required:

1. Review the Individual Service Plan (Form F-20445) to establish whether the entire cost share obligation has been correctly applied to one or more Waiver-covered allowable) service(s).
2. Before the CWA's transition to the TPA, the CWA can either report the cost share in HSRS under SPC 095.01 or apply the cost share to a specific service. Determine whether

the CWA is reporting cost share under SPC 095.01 or has a methodology to assure the service to which the cost share obligation is applied is being delivered and that the payment to the provider includes the cost-share.

3. Verify that the agency did not collect a cost share for any month where no waiver covered service was delivered or that the amount of the cost share applied did not exceed the total cost of services for that month.
4. For any cost share incurred on or after the county's transition date to TPA claims processing, verify that the county notified DHS of the amount of cost share collected.

CLTS E. County administrative costs

Compliance Requirements

County administrative costs are defined by the county waiver agency and are permitted in an amount up to seven percent (7%) of total waiver service costs in the CLTS Waivers. County administrative costs must be defined in writing by the county agency. The definition is subject to, but does not require, State approval. Generally, these are costs that cannot be easily attributable to a specific service but that represent the overall management of the service system. Examples of costs that are generally included are the cost of performing background checks on potential waiver service providers, the local cost of operating HSRS, equipment costs for electronic information systems for claims authorization or participant records, the cost of staff who perform data entry or other office support tasks, staff involved in a local quality management program, staff involved in contract management, the agency director and associated administrative support staff, etc. These costs shall be reported using the method prescribed by DHS. There must be written evidence that supports the claims.

Suggested audit procedure(s)

Determine whether the county has a written description of its method for ensuring it reports no more than the allowed limit and that it prevents the duplicate reporting of administrative costs.

Resources

- *Medicaid Waivers Manual* - http://dhs.wisconsin.gov/bdds/waivermanual/index.htm
- DLTC Memo Series - http://www.dhs.wisconsin.gov/partners/memos.htm
- Forms – http://dhs.wisconsin.gov/forms/index.htm - search by number
- HSRS Handbook - http://www.dhs.wisconsin.gov/HSRS/index.htm
- CLTS Service Codes Crosswalk
- Long-Term Care Encounter Reporting (Data Warehouse) - http://www.dhs.wisconsin.gov/LTCare/encounter/index.htm
- Medical Assistance Community-Based Services Updates. Copies are available from DLTC on request by calling (608) 261-6836.

Questions

Please send questions by email to DHSAuditors@Wisconsin.gov and include the identifier for the audit procedure (example - "PC A. Medicaid Audit of Personal Care Services") and the name of the auditee in the message.

Summary of Services by Program

http://www.dhs.wisconsin.gov/bdds/waivermanual/waiverch04_10.pdf#page=15

SERVICE CODE (SPC)	SERVICE NAME	ALLOWABLE IN THE CLTS WAIVER?
112.57	Adaptive Aids-Vehicle Related	Yes
112.99	Adaptive Aids- Other	Yes
102	Adult Day Care	No
202.01	Adult Family Home- 1-2 bed	Yes
202.02	Adult Family Home 3-4 bed	Yes
203	Children's Foster Care/ Treatment Foster Care	Yes
112.47	Communication Aids	Yes
506.61	Community Based Residential Facility	No
609.20	Consumer and Family Directed Supports	Yes
609.10	Consumer- Directed Supports	No
113	Consumer Education and Training	Yes
507.04	Counseling and Therapeutic Services	Yes
110	Daily Living Skills Training	Yes
706.10	Day Services-Adults	No
706.20	Day Services-Children	Yes
619	Financial Management Services	Yes
112.56	Home Modifications	Yes
402	Home-delivered meals	No
610	Housing counseling	Yes
106.03	Housing Start-up	Yes
512	Intensive In-home Autism Services	Yes
710	Nursing Services	Yes
112.46	Personal Emergency Response System (PERS)	Yes
108	Pre-vocational Services	No
103.22 103.24 103.26 103.99	Respite Care: Residential Institutional Home-based Other	Yes Yes Yes Yes
112.55	Special Medical and Therapeutic Supplies	Yes
107.30 107.40	Specialized Transportation - 1 way trips- Miles	Yes Yes
604	Support and Service Coordination	Yes
615	Supported Employment	Yes
104.10 104.20	Supportive Home Care - Days Hours	Yes Yes